TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ALLEN S. KENT, MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-2806-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
MAY 12, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am contacting you regarding this claim denial for procedure codes 29879 and 29876. At the time of the pre-authorization request and the surgery date, there was not a dispute on file. Therefore, the extent of injury denial is invalid. The audit date on the EOR coincides with the date that the PLN 11 dispute was given to our office. Please reprocess this claim."

Amount in Dispute: $4,750.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of the operative report demonstrates that codes 29879AS and 29876AS were procedures used to treat conditions unrelated to the compensable injury. (See operative report in the DWC60.) For this reason Texas Mutual declined to issue payment of the two codes."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 12, 2013	CPT Code 29881-RT	$1,097.52	$0.00
	CPT Code 29879-RT	$1,837.00	$0.00
	CPT Code 29876-RT	$1,816.00	$0.00
TOTAL		$4,750.52	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-219-Based on extent of injury (NOTE: To be used for workers' compensation only).
   - 246-The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 891-No additional payment after reconsideration.

Issues

1. Does an extent of injury issue exist in this dispute for codes 29879-RT and 29876-RT?
2. Is the requestor entitled to additional reimbursement for code 29881-RT?

Findings

1. Does medical fee dispute resolution have jurisdiction to review codes 29879-RT and 29876-RT rendered on July 12, 2013?

CPT Code	CPT Code Description	Amount Billed	Amount Paid	EOB Adjustment Code
29879-RT-AS	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture	$1,837.00	$0.00	CAC-219, 246, 891, CAC-193
29876-RT-AS	Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)	$1,815.99	$0.00	CAC-219, 246, 891, CAC-193

The requestor states that "the extent of injury denial is invalid."

The respondent states that reimbursement is not due because "Review of the operative report demonstrates that codes 29879AS and 29876AS were procedures used to treat conditions unrelated to the compensable injury. (See operative report in the DWC60.) For this reason Texas Mutual declined to issue payment of the two codes."

Unresolved extent-of-injury dispute: The medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f)(3)(C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent of injury dispute for the claim. 28 Texas Administrative Code § 133.307(c)(2)(K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

Extent-of-injury dispute process: The Division hereby notifies Stephanie Curtis, PA that the appropriate process to resolve the issue(s) of extent of injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the

Texas Labor Code, and 28 Texas Administrative Code §141.1. As a courtesy to Stephanie Curtis, PA, instructions on how to file for resolution of the extent of injury issue are attached.

Dismissal provisions: 28 Texas Administrative Code § 133.307(f)(3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code § 133.307. 28 Texas Administrative Code § 133.307(c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

2. Is the requestor due additional reimbursement for CPT code 29881-RT?

CPT Code	CPT Code Description	Amount Billed	Amount Paid	EOB Adjustment Code
29881-AS-RT	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	$1,790.00	$1,097.52	CAC-W1, 790

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service is 69.43.

The Medicare Conversion Factor is 34.023

Review of Box 32 on the CMS-1500 the services were rendered in zip code 76104, which is located in Fort Worth, TX; therefore, the Medicare participating amount is based on locality "Fort Worth, Texas".

The Medicare participating amount for code 29881 is $537.82.

Using the above formula, the MAR is $1,097.52. The respondent paid $1,097.52. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		05/27/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.